

EXHIBIT G



Aetna Life Insurance Company
Florida Disability Service Center
PO Box 14553
Lexington, KY 40512-4553

Angela A. Floyd
Short Term Disability Claim Analyst
1-888-382-3862
1-877-444-9788 (fax)

**** FILE COPY ****

August 16, 2007

[REDACTED]
[REDACTED]
[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS/Cert #: [REDACTED]

Dear [REDACTED]

We were informed that you return to work effective January 8, 2007. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on January 8, 2007. Since you were paid short term disability benefits through January 23, 2007, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period December 18, 2006 through January 23, 2007.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
December 18, 2006-January 23, 2006	\$1315.00	\$785.97	\$529.03
GROSS OVERPAYMENT			\$529.03
less EXCESS FICA WITHHELD PERIODS			\$40.47
NET OVERPAYMENT DUE			\$488.56

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

August 16, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$488.56. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

Aetna Life Insurance Company
P.O. Box 14553
Lexington, KY 40512-4553
Fax #: 1-877-444-9788

Your written request for review must be mailed or delivered to the address above within 180 days following receipt of this notice, or a longer period if specified in

3

August 16, 2007

your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



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****FILE COPY****

May 14, 2007

[REDACTED]
[REDACTED]
[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS#: [REDACTED]

Dear [REDACTED]:

We were informed by that you return to work briefly from July 18, 2006 through July 26, 2006. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on July 18, 2006. Since you were paid short term disability benefits from July 18, 2006 through July 26, 2006, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period July 18, 2006 through August 13, 2006.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
July 18, 2006-August 13, 2006	\$2108.58	\$1405.72	\$702.86
GROSS OVERPAYMENT			\$702.86
less EXCESS FICA WITHHELD PERIODS			\$53.77
NET OVERPAYMENT DUE			\$649.09

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

May 14, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$649.09. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

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May 14, 2007

your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



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Angela A. Floyd
Short Term Disability Claim Analyst
1-888-382-3862
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****MAINTAIN A COPY OF THIS LETTER FOR YOUR FILE****

April 24, 2007

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]

Dear [REDACTED]

We were informed that you return to work effective June 13, 2006. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on June 13, 2006. Since you were paid short term disability benefits through June 18, 2006, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period June 13, 2006 through June 18, 2006.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
June 13, 2006-June 18, 2006	\$241.83	\$0.00	\$241.83
GROSS OVERPAYMENT			\$241.83
less EXCESS FICA WITHHELD PERIODS			\$15.63
NET OVERPAYMENT DUE			\$226.20

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

April 24, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$226.20. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

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Fax #: 1-877-444-9788

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3

April 24, 2007

the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



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Angela A. Floyd
Short Term Disability Claim Analyst
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****FILE COPY****

June 11, 2007

[REDACTED]
[REDACTED]
[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS/ Cert #: [REDACTED]

Dear [REDACTED]:

We were informed that you return to work effective December 26, 2006. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on December 26, 2006. Since you were paid short term disability benefits through December 27, 2006, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period December 21, 2006 through December 27, 2006.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
December 21, 2006-December 27, 2006	\$897.41	\$641.02	\$256.39
GROSS OVERPAYMENT			\$256.39
less EXCESS FICA WITHHELD PERIODS			\$19.61
NET OVERPAYMENT DUE			\$236.78

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

2

June 11, 2007

As stated above, you were overpaid \$236.78. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

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Fax #: 1-877-444-9788

Your written request for review must be mailed or delivered to the address above within 180 days following receipt of this notice, or a longer period if specified in your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances

3
June 11, 2007

require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
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Short Term Disability Claim Analyst
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****MAINTAIN A COPY OF THIS LETTER FOR YOUR FILE****

January 2, 2007

[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS#: [REDACTED]

Dear [REDACTED]

We were informed that you return to work effective November 27, 2006. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on November 27, 2006. Since you were paid short term disability benefits through November 29, 2006, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period November 21, 2006 through November 29, 2006.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
November 21, 06-November 27, 06	\$422.25	\$361.93	\$60.32
November 28, 06-November 29, 06	\$120.64	\$0.00	\$120.64
GROSS OVERPAYMENT			\$180.96
less EXCESS FICA WITHHELD PERIODS			\$13.89
NET OVERPAYMENT DUE			\$167.07

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

2

January 2, 2007

As stated above, you were overpaid \$167.07. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

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Lexington, KY 40512-4553
Fax #: 1-877-444-9788

Your written request for review must be mailed or delivered to the address above within 180 days following receipt of this notice, or a longer period if specified in your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances

3

January 2, 2007

require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



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Short Term Disability Claim Analyst
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****FILE COPY****

November 13, 2007

[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS/Cert No: [REDACTED]

Dear [REDACTED]

We were informed that you return to work effective April 11, 2007. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on April 11, 2007. Since you were paid short term disability benefits through April 18, 2007, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period April 5, 2007 through April 18, 2007.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
April 5, 2007 - April 11, 2007	\$318.93	\$273.37	\$45.56
April 12, 2007 - April 18, 2007	\$318.93	\$0.00	\$318.93
GROSS OVERPAYMENT			\$364.49
less EXCESS FICA WITHHELD PERIODS			\$27.89
NET OVERPAYMENT DUE			\$336.60

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

November 13, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$336.60. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

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November 13, 2007

your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

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If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



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Angela A. Floyd
Short Term Disability Claim Analyst
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****FILE COPY****

November 15, 2007

[REDACTED]
[REDACTED]
[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS/ Cert No: [REDACTED]

Dear [REDACTED]:

We were informed that you return to work effective May 7, 2007. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on May 7, 2007. Since you were paid short term disability benefits through May 7, 2007, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period May 1, 2007 through May 7, 2007.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
May 1, 2007 – May 7, 2007	\$496.87	\$425.89	\$70.98
GROSS OVERPAYMENT			\$70.98
less EXCESS FICA WITHHELD PERIODS			\$5.43
NET OVERPAYMENT DUE			\$65.55

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

November 15, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$65.55. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

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November 15, 2007

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If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



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****FILE COPY****

November 20, 2007

[REDACTED]
[REDACTED]
[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications Corporation
Employee: [REDACTED]
SS/Cert No: [REDACTED]

Dear [REDACTED]

We were informed that you return to work effective May 7, 2007. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on May 7, 2007. Since you were paid short term disability benefits through May 10, 2007, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period May 4, 2007 through May 10, 2007.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
May 4, 2007-May 10, 2007	\$381.87	\$163.66	\$218.21
GROSS OVERPAYMENT			\$218.21
less EXCESS FICA WITHHELD PERIODS			\$16.69
NET OVERPAYMENT DUE			\$201.52

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

November 20, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$201.52. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

Aetna Life Insurance Company
P.O. Box 14553
Lexington, KY 40512-4553
Fax #: 1-877-444-9788

Your written request for review must be mailed or delivered to the address above within 180 days following receipt of this notice, or a longer period if specified in

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November 20, 2007

your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications Corporation



Aetna Life Insurance Company
Florida Disability Service Center
PO Box 14553
Lexington, KY 40512-4553

Angela A. Floyd
Short Term Disability Claim Analyst
1-888-382-3862
1-877-444-9788 (fax)

****FILE COPY****

May 11, 2007

[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS#: [REDACTED]

Dear [REDACTED]

We were informed by your employer that you return to work effective October 2, 2006. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on October 1, 2006. Since you were paid short term disability benefits through October 2, 2006, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period September 27, 2006 through October 2, 2006.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMEN T AMOUNT
September 27, 2006-October 2, 2006	\$406.10	\$338.66	\$67.44
GROSS OVERPAYMENT			\$67.44
less EXCESS FICA WITHHELD PERIODS			\$5.15
NET OVERPAYMENT DUE			\$62.29

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

May 11, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$62.29. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

Aetna Life Insurance Company
P.O. Box 14553
Lexington, KY 40512-4553
Fax #: 1-877-444-9788

Your written request for review must be mailed or delivered to the address above within 180 days following receipt of this notice, or a longer period if specified in

3

May 11, 2007

your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications



Aetna Life Insurance Company
Florida Disability Service Center
PO Box 14553
Lexington, KY 40512-4553

Angela A. Floyd
Short Term Disability Claim Analyst
1-888-362-3862
1-877-444-9788 (fax)

**** FILE COPY ****

August 16, 2007

[REDACTED]

Short Term Disability Benefits

Group Control No: 619308
Employer: Mediacom Communications
Employee: [REDACTED]
SS/ Cert #: [REDACTED]

Dear [REDACTED]

We were informed by that you return to work effective March 5, 2007. According to the provisions of your short term disability plan, benefits are to cease once an employee returns to work earning reasonable wage. Therefore, your eligibility to receive short term disability benefits was terminated on March 4, 2007. Since you were paid short term disability benefits through March 5, 2007, an overpayment has occurred on your claim.

The calculation below shows your overpayment for the period February 27, 2007 through March 5, 2007.

BENEFIT PERIODS	AMOUNT ISSUED TO YOU	less AMOUNT DUE	equals OVERPAYMENT AMOUNT
February 27, 2007-March 5, 2007	\$279.57	\$239.63	\$39.94
GROSS OVERPAYMENT			\$39.94
less EXCESS FICA WITHHELD PERIODS			\$3.06
NET OVERPAYMENT DUE			\$36.88

Since you received weekly benefits in excess of your entitlement, please immediately reimburse the outstanding overpayment amount indicated above.

2

August 16, 2007

Social Security (FICA) withholding is required during the first six full months of disability. FICA withholding will cease if you continue to remain totally disabled beyond six full calendar months.

As stated above, you were overpaid \$36.88. Please forward your check or money order payable to Aetna Life Insurance Company, in the enclosed self-addressed envelope.

You must respond to this request within 15 days from the date of this letter. Failure to respond will result in our taking further action including referral of this matter to a collection agency for handling.

The amount of the above overpayment has been reduced by a FICA credit. The amount of the FICA credit will be reimbursed directly to Aetna by the IRS. Therefore, you should not request reimbursement from the IRS.

Please enter your Social Security Number, sign, date, and return this letter with reimbursement of the above overpayment. Your reimbursement cannot be processed and your benefits cannot be resumed prior to receipt of this signed letter.

"I will not seek reimbursement of withheld FICA amounts directly from the IRS. The amount of reimbursement due to Aetna has been adjusted for FICA withholding."

Social Security Number: _____

Signature: _____ Date: _____

You are entitled to a review of this decision if you do not agree.

To obtain a review, you or your authorized representative should submit a written request. Your request should include your group's name (e.g. employer), your name, social security number, other pertinent identifying information, comments, documents, records and other information you would like to have considered. You may also ask for copies or documents relevant to your request. Please mail or fax your request for appeal to:

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P.O. Box 14553
Lexington, KY 40512-4553
Fax #: 1-877-444-9788

Your written request for review must be mailed or delivered to the address above within 180 days following receipt of this notice, or a longer period if specified in

3

August 16, 2007

your plan brochure or Summary Plan Description. You will receive notification of the final determination within 45 days following receipt of your request. This period may be extended up to an additional 45 days if special circumstances require such an extension, in which case you will be notified prior to the end of the first 45 day period.

If your plan is covered under the Employee Retirement Income Security Act (ERISA), and you do not agree with the final determination upon review, you have the right to bring a civil action under section 502(a) of ERISA.

If the determination was made based on the definition of disability, or similar limitation or exclusion, an explanation of the scientific or clinical judgment for the determination, applying terms of the plan to your medical condition, will be provided free of charge upon request by you or your authorized representative.

In any event, a copy of the specific rule, guideline or protocol relied upon in the adverse determination will be provided free of charge upon your or your authorized representative's request.

If you have any questions, please call 1-888-382-3862.

Sincerely,

Angela A. Floyd, DCA
Aetna Life Insurance Company

cc: Mediacom Communications